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F 000	INITIAL COMMENTS The following citations represent the findings of an initial Health Survey and Complaint Investigation #57799.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These

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requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 53 residents. Based on observation and interview the facility failed to prominently display information for residents, staff, and visitors to contact the State Complaint Hotline.

Findings included:

- On 10-15-12 at approximately 11:05 A.M. during the environmental tour, observation revealed the State Complaint Hotline information was posted by the dining room entrance along the back hallway.

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F 156	Continued From page 3 On 10-15-12 at 11:10 A.M. administrative staff A acknowledged the Complaint Hotline information was posted on the back hallway and stated all visitors entered the front entrance and usually went to the dining room. The facility failed to prominently display the State Complaint Hotline information for all residents, staff, and visitors to view.	F 156		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. Based on observation, record review, and interview the facility failed to obtain a reference check for 1 of 5 staff reviewed for abuse prohibition. Findings included: - During review for employee screening, record review revealed the facility failed to obtain a reference check for 1 dietary staff Q. On 10-11-12 at 3:27 P.M. administrative staff O acknowledged the employee file lacked reference checks and stated the company the facility contracted for food service found the employee then the facility hired them.	F 226		

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F 226	Continued From page 4 The 03/12 facility provided Resident Abuse Policy and Procedure documented screening of employees included reference checks from previous or current employers. The 4/07 facility provided Employment Application Procedure documented that all references provided by an applicant was checked prior to employment of the applicant. The facility failed to complete reference checks as requested.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The facility failed to maintain a provide a sanitary, comfortable, homelike environment for residents on 3 of 3 units and common areas. Findings included: - During the environmental tour on 10-15-12 beginning at 10:10 A.M. observation of the 100 hall locked unit revealed resident rooms with screws protruding out of the wall, wall spackle on the walls without paint, and chipped caulking around toilets. - Observation of the community shower room revealed tiles chipped, grout stained in the	F 253		

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shower stall, caulking stained around the bottom of the toilet, and a marred wall with chipped paint by the paper towel dispenser.

- Observation of the unit 1 shower room revealed chipped and missing tile, stained grout, and large amount of chipped paint on the doorway into the bathroom.

- Observation of the unit 2 shower room revealed chipped tiles, chipped floor tile, and the faucet with corrosion.

- Observation of the unit 2 south shower room revealed a ceiling light fixture broken, a large chunk of wood missing on the door into the bathroom, and stained grout.

- Observation of resident room on the 200 hall revealed spackling on the walls not covered with paint, flooring chipped, cracked, broken and mis-matched.

- Observation of the activity room/restorative room revealed multiple pin holes in the wall.

- Observation of the hallway by the dining room revealed areas of spackling not covered with paint.

- Observation of the beauty shop revealed the counter top and cabinet with exposed wood where the surface chipped off.

During staff interview on 10-15-12 during the environmental tour from 10:10 A.M. until 11:10 A.M. administrative staff A and maintenance staff V acknowledged the findings. Administrative staff

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F 253	Continued From page 6 A stated the facility began painting and repairing the resident rooms and anticipated completion of the rooms by December 2012. He/she stated the maintenance staff were doing the repairs and painting. The facility lacked a policy and procedure for upkeep and repairs of the building. The facility failed to maintain a clean and sanitary environment for the residents.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		

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F 279	Continued From page 7 The facility identified a census of 53 residents. The sample included 16 residents. Based on observation, interview and record review, the facility failed to develop a comprehensive, individualized incontinence care plan for 1 resident. (#1) Findings included: - Resident #1's Incontinence Potential for Bowel/Bladder Training assessment dated 9/27/12 identified the resident was a good candidate for individualized training because he/she voided correctly without incontinence at least once per day, he/she was incontinent of stool 1-3 times per week, he/she needed staff assistance for transfer to the toilet, he/she was forgetful but able to follow commands and he/she was usually aware of toileting needs. The care plan dated 7/24/12 directed staff to provide limited to extensive assistance to manage the resident's incontinence of bowel and bladder. The care plan lacked individualized interventions regarding the resident's toileting and incontinence needs. Observation on 10/11/12 at 2:44 P.M. revealed the resident sat in his/her wheelchair near the nurse's station and communicated with the licensed nurse. During an interview on 10/11/12 at 3:18 P.M., direct care staff BB stated staff assisted the resident to transfer to the toilet and used the gait belt to keep the resident steady. The resident was	F 279		

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incontinent at times of bowel and bladder, he/she had dialysis sessions 3 times per week and was weaker after dialysis and had more incontinent episodes, the resident wore a brief at all times, the resident was alert and oriented and told the staff when he/she had to use the toilet, so staff did not offer to toilet the resident.

During an interview on 10/15/12 at 12:29 P.M., licensed staff H stated the resident was incontinent of bowel sometimes because he/she had loose stools and could not wait for assistance to the toilet, he/she asked for assistance to the bathroom and always wore the brief because he/she had loose stools and the resident was continent of urine.

During an interview on 10/15/12 at 12:26 P.M., direct care staff EE stated staff used a gait belt and guided the resident to the restroom, most of the time the resident told staff when he/she had to go, the resident rarely had an incontinence episode and staff offered to take the resident to the toilet every 2 hours. The resident was continent of bowel, and incontinent of urine.

During an interview on 10/15/12 at 1:58 P.M., administrative nursing staff B stated direct care staff used the Kardex to determine which care the resident needed, the Kardex was not a care plan and it was not part of the care plan. Staff B acknowledged the Kardex informed staff that the resident was both continent of bowel and bladder and also incontinent, and acknowledged the facility lacked a toileting or incontinence care plan for the resident.

The facility-provided policy entitled Care Plan

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F 279	Continued From page 9 dated 3/12 directed the facility to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. The care plan coordinator developed the current care plan by addressing all unresolved problems from the previous care plan and/or noting on the care plan all new problems, approaches and target dates as they were identified in the current resident assessment, the care area assessments, the medical record, resident contact and staff input. All problems and category of needs were addressed and the plan was oriented toward preventing a decline in functioning. The facility failed to develop a comprehensive, individualized toileting or incontinence care plan for this resident.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility reported a census of 53 residents. The sample included 16 residents. Based on observation, record review, and staff interview the facility failed to provide accurate skin	F 309		

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assessments for 2 (#13 and #15) of 3 residents sampled for skin abrasions/bruises.

Findings included:

- The Physician's Order Sheet (POS) dated 9/27/12 for resident #13 revealed diagnoses of Alzheimer's (difficulty with memory), difficulty in walking, lack of coordination, and dementia (difficulty with memory) with behaviors.

The revised care plan dated 7/31/13 recorded the resident was at risk for alteration in continence and skin integrity related to dementia, mood disorder, and decreased mobility as evidenced by needing limited to extensive assistance with activities of daily living, (ADL) and directed staff to complete a weekly skin assessment.

The Weekly Skin Integrity Check sheets, completed by licensed nursing staff, dated 9/25/12, 9/29/12, 10/2/12, 10/3/12, 10/5/12, 10/11/12, and 10/12/12 revealed the resident's skin was clear with no change of condition.

The Bath Sheets dated 9/11/12, and 9/25/12 revealed the resident did not have any skin issues.

The Bath Sheets dated 10/2/12, 10/5/12, and 10/9/12 revealed staff identified an open area, a bruised, a red area, a rash on the form with an X and co-signed with a nurse's signature.

The Weekly Nursing Progress notes dated 9/8/12, 9/15/12, 9/22/12, 9/29/12, and 10/3/12 revealed the resident's skin was warm, dry, and intact; and had no skin issues noted/no concerns.

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F 309	Continued From page 11 Observation on 10/10/12 at 12:30 P.M. revealed the resident ambulated in the hallway with a front wheel walker, wore sweats and a long sleeve coat, and no bruising noted to her/his face/hands. Observation on 10/11/12 at 7:15 A.M. revealed the resident was in the process of getting dressed; and did not have bruising or abrasions noted to the lower extremities, face, or hands. Staff interview on 10/11/12 at 1:23 P.M. with direct care staff K stated the resident did not have any bruising/abrasions in the past 60 days; and she/he would inform the charge nurse of any skin concerns and document on the skin assessment sheet. Family interview on 10/11/12 at 2:30 P.M. stated she/he had not seen any bruises/abrasions/skin tears on the resident for the past 60 days; staff were very good at notifying her/him for any problems; and staff checked the resident's skin while she/he was in the shower. Staff interview on 10/11/12 at 2:53 P.M. with direct care staff L stated she/he had not noted any skin tear/bruises/abrasions on the resident when she/he provided showers on the evening shift; she/he would inform the nurse of any skin concerns and show her/him the area of concern; and she/he documented skin concerns on the shower sheet. Staff interview on 10/11/12 at 3:21 P.M. with licensed nursing staff E stated she/he did not recall any skin issues with the resident; and would expect the bath aide to inform her/him of any skin	F 309		

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concerns so appropriate measures could be taken.

Staff interview on 10/15/12 at 10:11 A.M. with licensed nursing staff F stated the resident did not have any skin issues since August 2012; the certified nursing aide (CNA) would inform the nurse if she/he noted any skin issues, the nursing staff assessed the resident while in the bath/shower; nursing staff notified the physician of skin issues and treatment; and initiated a skin observation sheet.

Staff interview on 10/15/12 at 12:36 P.M. with licensed nursing staff F stated it was an error on the bath sheets dated 10/2/12, 10/5/12, and 10/9/12 as the resident did not have skin issues; the nurse's signature on the sheet indicated the nurse reviewed the bath sheet; if the CNA provided her/him with a bath sheet with skin issues, she/he would asses the resident's skin; and if the CNA's documentation was incorrect, she/he would educate the CNA on proper completion of the bath sheet.

Staff interview on 10/15/12 at 2:25 P.M. with licensed nursing staff E stated her/his signature on the bath sheets dated 10/2/12, 10/5/12, and 10/9/12 indicated she/he agreed with the CNA's observation on the bath sheet; if the CNA's documentation indicated skin issues she/he would assess the resident; and if the documentation was inaccurate she/he would educate the CNA on proper completion of bath sheets.

Staff interview on 10/15/12 at 2:32 P.M. with Administrative Nursing Staff B stated the charge

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nurse signed the bath sheets for accuracy; the bath sheets go into the 24 hour book for review by the unit manager and Director of Nursing (DON); if staff noted concerns, the bath sheet was returned to the nurse and they would assess the resident; and would expect the nurse to complete a bruise investigation form or a non-decubitus sheet.

The Policy and Procedure dated 3/12 for Bruise Investigation revealed staff must complete a bruise investigation within 12 hours.

The facility failed to accurately assess this resident's skin integrity.

- Resident #15's Physician Progress note dated 8-19-12 documented the resident was non-verbal and in a vegetative state.

The 7-25-12 care plan documented the resident had fragile skin and directed staff to document changes in skin, provide weekly skin checks, apply moisture, and report any red areas to the nurse immediately. An undated entry documented the resident with a scratch on the resident's right flank area and directed staff to apply lotion and observe the resident. The care plan documented the resident had a medical diagnosis that required the need for anticoagulation (to thin the blood) and was at risk for increased bleeding and bruising and interventions directed staff to assess for internal bleeding and abnormal bruising.

Record review of the nurse's notes on 10-12-12 at 2:00 P.M. documented the resident with 2

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bruises on the left thigh approximately 1 1/2 inches in size and a bruise on the right thigh approximately 1 inch in size and was green/yellow in color.

On 10-13-12 with the time illegible the nurse's note documented the bruise on the right thigh persisted, was green/yellow in color and the bruise was resolving.

On 10-14-12 with no time written, the nurse's note documented the bruise on the left thigh was resolving and the resident had a scratch on his/her right flank area that was thin, straight, approximately 5 inches in length and scabbed over.

Observation on 10-15-12 at 1:30 P.M. revealed the resident with multiple small bruises on both his/her upper arms green/yellow in color, multiple bruises on the residents abdomen, 2 bruises on the resident's left lateral upper calf area just below the knee and 1 bruise green/yellow in color on the resident's right lateral upper calf area just below the knee. Observation revealed a long scabbed scratch on the resident's right rib area below the resident's arm pit. The scratch was approximately 12-14 centimeters (cm) in length with minimal width.

Record review of the weekly skin assessments dated 10-5-12 and 10-12-12 lacked documentation of the multiple bruises on the resident's upper arms and abdomen. The 10-12-12 weekly skin assessment lacked the appropriate location of the bruises on the resident's lateral right and left calves.

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F 309	Continued From page 15 The record lacked evidence staff identified and monitored each bruise on the resident's arms or abdomen. During staff interview on 10-15-12 at 2:00 P.M. licensed nurse H stated the resident received bruises on his/her upper arms and abdomen because of the insulin injections he/she received and the resident also received Coumadin (a medication used to prevent blood clots or prevent an increase in the size of a blood clot). Licensed nurse H acknowledged the documentation of the bruises on the resident's thighs in the nurses' notes and stated that was inaccurate and the bruises were below the resident's knees and staff should have recorded as such. During staff interview on 10-15-12 at 3:20 P.M. administrative nurse B acknowledged the resident's bruises on the resident's calves and acknowledged the documentation in the resident's record was not accurate and identified it when he/she began the investigation for the bruises. He/she stated the nursing assistant's bath sheet identified the bruises on the resident's calves. He/she also stated the bruises on the resident's upper arms and abdomen were caused by insulin injections and stated the resident received the bruises because of his/her Coumadin use which was in the care plan. During staff interview on 10-15-12 at approximately 3:40 P.M. administrative consultant W stated staff investigated all bruises and used the Bruise investigation form. The facility lacked a policy regarding monitoring of skin concerns that included bruises.	F 309		

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F 309	Continued From page 16 The facility failed to accurately document and monitor the resident's bruises on his/her upper arms and abdomen and failed to appropriately assess the resident's bruises on his/her calves.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents and a sample of 16 residents. Based on observation, record review and interview, the facility failed to reposition in a timely manner 1 of 3 residents sampled who were at risk for pressure ulcers. (#2) Findings included: - Resident #2's October 2012 Physician's Order Sheet (POS) recorded the resident with a low air loss mattress. The care plan dated 10-1-12 recorded the resident with a self-care deficit, the resident did not bear weight, had weakness and decreased endurance and directed staff to reposition the	F 314		

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resident for comfort. The care plan recorded the resident was at risk for skin breakdown and directed staff to turn and reposition the resident often.

The Quarterly Data Collection Tool dated 10-4-12 recorded the resident was at risk for pressure ulcers.

Observation on 10-10-12 revealed the following:

7:36 A.M. staff wheeled the resident out of his/her room to the dining room
7:46 A.M., 7:59 P.M., 8:02 A.M., 8:05 A.M., 8:17 A.M., 8:22 A.M., 8:35 A.M., 8:46 A.M., and 9:01 A.M. the resident sat in his/her wheelchair at the dining room table eating breakfast
9:19 A.M. the resident sat in his/her wheelchair in his/her room
9:29 P.M. licensed nursing staff D walked by the resident's room, looked in at him/her and walked down the hall
9:41 A.M. resident remained in his/her room in his/her wheelchair
9:56 A.M. resident remained in his/her room, licensed nursing staff C entered the resident's room, then left without repositioning the resident
9:58 A.M. bed alarm sounded from the resident's room, direct care staff M and licensed nursing staff C entered the resident's room, shut off the alarm and exited the room, staff did not reposition the resident, the resident remained in his/her wheelchair
10:08 A.M. licensed nursing staff C entered the resident's room, ask if he/she wanted to lay down
10:18 A.M. direct care staff M applied a gait belt to the resident, transferred the resident to the bed, and removed the gait belt; direct care staff M

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applied gloves, removed the resident's pants and incontinent brief soiled with urine; staff provided incontinent care and repositioned the resident facing the window; staff placed the heel cradle under the resident's calves.

The staff did not reposition this resident for a total of 2 hours and 42 minutes.

During interview on 10-11-12 at:

12:55 P.M., licensed nursing staff C stated the resident did not have any pressure ulcers, and was incontinent of bowel and bladder.

1:51 P.M. licensed nursing staff G stated the resident was incontinent of bowel and bladder, and staff should reposition and check and change him/her every 2 hours.

During interview on 10-15-12 at:

11:00 A.M., licensed nursing staff D stated the resident did not have pressure ulcers currently, was incontinent of bowel and bladder, and staff should check and change and reposition the resident at least every 1 ½ - 2 hours. The resident could not reposition him/herself.

12:02 P.M. direct care staff N stated the resident was incontinent of bowel and bladder, did not have pressure ulcers, could not turn him/herself, and staff should check and change and reposition the resident every 2 hours.

2:36 P.M., direct care staff P stated the resident was at risk for pressure ulcers, was incontinent of bowel and bladder and staff should reposition the

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F 314	Continued From page 19 resident every 2 hours. 2:44 P.M., administrative nursing staff B stated the staff should reposition and check and change the resident every 2-3 hours. The un-dated facility provided policy entitled Pressure Sore Prevention At A Glance directed staff to turn and reposition residents at least every 2 hours when in bed, every hour when in the chair and to manage urinary/fecal incontinence and clean and protect every 1-2 hours. The facility failed to check and change or reposition this cognitively impaired, dependent resident who was at risk for pressure ulcers in a timely manner.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 16 residents. Based on observation, record review and interview, the	F 315		

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facility failed to provide timely incontinent care for 1 of 4 residents sampled for incontinence (#2) and failed to provide appropriate perineal care for 1 of 4 residents sampled for incontinence (#9).

Findings included;

- Resident #2's The Weekly Nursing Progress Notes dated 9-13-12 recorded the resident was incontinent of bowel and bladder and staff should check and change the resident every 2 hours.

The nurse tech information kardex directed staff to provide incontinent check and change care routinely.

The care plan dated 10-2-12 directed staff to provide incontinence care as needed.

Observation on 10-9-12 revealed at:

7:36 A.M. staff wheeled the resident out of his/her room to the dining room
7:46 A.M., 7:59 P.M., 8:02 A.M., 8:05 A.M., 8:17 A.M., 8:22 A.M., 8:35 A.M., 8:46 A.M., and 9:01 A.M. the resident sat in his/her wheelchair at the dining room table eating breakfast
9:19 A.M. the resident sat in his/her wheelchair in his/her room
9:29 P.M. licensed nursing staff D walked by the resident's room, looked in at him/her and walked down the hall
9:41 A.M. resident remained in his/her room in his/her wheelchair
9:56 A.M. resident remained in his/her room, licensed nursing staff C entered the resident's room, then left without checking the resident for incontinence

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9:58 A.M. bed alarm sounded from the resident's room, direct care staff M and licensed nursing staff C entered the residents room, shut off the alarm and exited the room, staff did not check the resident for incontinence and the resident remained in the wheelchair
10:08 A.M. licensed nursing staff C entered the resident's room, and asked if he/she wanted to lay down
10:18 A.M. direct care staff M applied a gait belt to the resident, transferred the resident to the bed, and removed the gait belt; direct care staff M applied gloves, removed the resident's pants and incontinent brief soiled with urine; staff provided incontinent care and repositioned the resident facing the window.

The staff did not check and change the resident for a total of 2 hours and 42 minutes.

During interview on 10-11-12 at:

12:55 P.M., licensed nursing staff C stated the resident was incontinent of bowel and bladder.

1:51 P.M. licensed nursing staff G stated the resident was incontinent of bowel and bladder, and staff should reposition and check and change him/her every 2 hours.

During interview on 10-15-12 at:

11:00 A.M., licensed nursing staff D stated the resident was incontinent of bowel and bladder, and staff should check and change and reposition the resident at least every 1 ½ - 2 hours.

12:02 P.M. direct care staff N stated the resident

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was incontinent of bowel and bladder, and staff should check and change and reposition the resident every 2 hours.

2:36 P.M., direct care staff P stated the resident was incontinent of bowel and bladder.

2:44 P.M., administrative nursing staff B stated the resident should be repositioned and check and changed every 2-3 hours.

The facility provided policy entitled Incontinent Resident Care dated 3/12 did not specify a time frame for checking and changing and providing incontinent care for residents.

The facility failed to check and change this cognitively impaired, dependent, incontinent resident as planned.

- Resident #9's current incontinence care plan dated 7/24/12 directed staff to provide incontinent care and perineal care with each of the resident's incontinent episodes, provide total care for activities of Daily Living (ADLs), provide a Broda chair for mobility, and check and change the resident's brief for incontinence routinely and as needed.

The current skin care plan dated 7/24/12 directed staff to provide perineal care after each incontinent episode, perform routine skin assessments weekly and as needed and turn and reposition the resident as clinically indicated, every 2 hours.

The Quarterly Data Collection Tool dated 10/8/12 identified the resident was not a candidate for a

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timed toileting program.

The Weekly Nursing Progress Notes dated 10/5/12 and 10/12/12 recorded staff identified the resident as incontinent of bladder and bowel.

Observation in the resident's room on 10/10/12 at 9:08 A.M. revealed direct care staff Z and direct care staff AA checked the resident's incontinence brief, stated the brief was wet and removed it. Staff failed to clean the resident in the front part of his/her body, and rolled the resident to his/her side. Direct care staff Z applied foaming body wash to a dry washcloth and began to clean the area between the resident's buttocks when the resident began to have a bowel movement (BM). Staff placed a clean brief on the resident, allowed the resident time to finish his/her BM, and when finished removed the soiled brief and cleaned the area between the resident's buttocks with foaming body wash applied to a dry washcloth 2 times. Staff failed to clean the front of the resident's body and failed to clean the resident's buttocks.

During an interview on 10/15/12 at 12:23 P.M., licensed staff H stated he/she expected direct care staff to check and change the resident's incontinence brief every 2 hours and clean all the skin that came in contact with the brief.

During an interview on 10/15/12 at 1:21 P.M., direct care staff BB stated when staff cleaned a resident after incontinence; they should use a wet washcloth with soap and water after a bowel movement, then follow with a wet washcloth with the foaming body wash, clean from the front to the back of the resident's body and dry the skin.

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F 315	Continued From page 24 During an interview on 10/15/12 at 2:15 P.M., direct care staff CC stated direct care staff should use warm wet washcloths and perineal wash, clean from the front of the resident's body to the back and clean the entire skin wherever the brief touched the resident's skin. During an interview on 10/15/12 at 2:20 P.M., administrative nursing staff B stated he/she expected staff to wet the washcloth, use either soap or body wash to clean the resident, wash all the resident's skin that had contact with the brief and dry the skin. Staff B acknowledged direct care staff did not provide perineal care properly for the resident because they did not wet the washcloth and did not wash all of the resident's skin that came in contact with the incontinence brief. The facility provided the policy entitled Incontinent Resident Care dated 3/12 which directed, "Wash, rinse and dry the skin, being certain to expose all skin surfaces which are soiled. " The facility failed to provide complete perineal care for this dependent resident.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 25 This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. Based on observation and interview the facility failed to maintain a non-slip surface in 4 of 4 shower rooms. Findings included: - On 10-15-12 during the environmental tour between 10:10 A.M. and 11:10 A.M. observation revealed the shower room on the locked special care unit, the 100 hall shower room and both 200 hall shower rooms lacked a non-slip surface for the shower areas and/or tub areas. Maintenance staff V and administrative staff A acknowledged the findings. The facility failed to maintain a non-slip surface in the shower and/or tub areas for 4 of 4 shower rooms observed.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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F 329	Continued From page 26 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 16 residents. Based on observation, record review and interview, the facility failed to monitor the effectiveness of as needed pain medication and failed to provide medication as ordered for one resident (#2) and failed to provide adequate behavior monitoring for one resident (#8) of 3 residents sampled for unnecessary medications. Findings included: - Resident #2's September 2012 Medication Administration Record (MAR) recorded the resident received as needed Lortab (narcotic pain medication) as ordered on 9-3-12 at 7:00 A.M.; 9-6-12 at 6:20 A.M. and 4:00 P.M.; 9-9-12 at 4:30 P.M.; 9-18-12 at 3:45 P.M. and 9-19-12 at 2:30 P.M. staff documented only once on the back of the MAR that the resident received the Lortab and the effectiveness. The facility failed to document the reason for the medication administration, location of pain and follow-up	F 329		

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effectiveness in a timely manner after administration on 4 of the 6 times the resident received Lortab in the month of September 2012.

The care plan dated 10-2-12 directed staff to assess the resident for pain and medicate as ordered by the physician.

The Weekly Nursing Progress Note dated 10-8-12 recorded the resident with pain less than daily and had as needed Lortab.

Observation on 10-9-12 at 4:39 P.M. revealed the resident in his/her wheelchair in his/her room.

During an interview on 10-15-12 at 2:44 P.M., administrative nursing staff B stated staff should follow up on as needed medications within the hour and staff should document on the pain flow sheet.

During interview on 10-15-12 at 2:45 P.M., consultant staff W stated the follow up on pain medications should be on the pain flow record.

During interview on 10-15-12 at 3:01 P.M., consultant staff W acknowledged the effectiveness of the Lortab in September was not always documented.

The facility-provided policy entitled Pain Assessment dated 3/12 recorded a pain flow record would be maintained with the resident's Medication Administration Record. This was to be completed when the resident identified they had pain. Staff should record the date and time, site/location, intensity, precipitating/aggravating, interventions-medication/non-medication,

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F 329	Continued From page 28 intensity of pain after intervention, side effects and initials. The facility failed to evaluate the effectiveness of the as-needed pain medication for this cognitively impaired, dependent resident. - Resident #2's physician signed October 2012 Physician's Order Sheet (POS) recorded a diagnosis of hypertension. (elevated blood pressure) The care plan dated 10-2-12 directed staff to medicate the resident as ordered by the physician. Nurse's notes dated 9-28-12 (no time recorded) documented the resident's blood pressure at 6:30 P.M. was 230/77. Staff received a new order to administer Clonidine (blood pressure medication) 0.1 milligrams when the resident's systolic blood pressure was greater than 180 as needed three times a day. The October 2012 Medication Administration Record (MAR) recorded blood pressures as follows: 10-4-12 182/94 10-5-12 192/87 10-6-12 184/70 10-8-12 184/80 10-9-12 182/84 The MAR lacked evidence the resident received Clonidine as ordered on these dates. On 10-9-12 at 4:39 P.M., observation revealed the resident sat in his/her wheelchair in his/her	F 329		

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F 329	Continued From page 29	F 329		

room.

On 10-11-12 at 12:55 P.M., licensed nursing staff C acknowledged staff should have administered the current order of as needed Clonidine 5 times this month and the staff did not administer this medication.

During an interview on 10-15-12 at 3:01 P.M., administrative nursing staff B acknowledged the resident had 5 missed doses of Clonidine and started the incident report with 3 staff. Administrative nursing staff B stated staff called the physician and received an order to discontinue the Clonidine. Administrative nursing staff B stated the management team checked the MARs every day or every other day for accuracy and completeness.

The facility failed to provide this cognitively impaired, dependent resident with blood pressure medications as ordered by the physician.

- The Physician's Order Sheet (POS) dated 9/28/12 for resident #8 revealed diagnoses of senile dementia (difficulty with memory), Alzheimer's disease (difficulty with memory), psychosis (an abnormal condition of the mind), and anxiety disorder (a pattern of constant worry).

The Quarterly Minimum Data Set (MDS) dated 8/29/12 revealed the resident had long/short term memory problems; severely impaired cognitive skills for daily decision making; physical behavioral symptoms directed toward others with behaviors that occurred 1 to (-) 3 days; rejected care which occurred 1-3 days; required extensive assist with two plus (2+) persons assisting with

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bed mobility, transfers, walk in room/corridor, locomotion on the unit, dressing, eating, toileting, and personal hygiene; total dependence of 2+ persons assisting with bathing; and received antipsychotic medications.

The care plan dated 9/12/12 recorded the resident at risk for adverse side effects for antipsychotics and antidepressants and directed nursing staff to administer medications as ordered; monitor for signs and symptoms of adverse effects of antidepressant medications; monitored for adverse effects of psychotropic medication; monitored for signs and symptoms of adverse effects of antianxiety medications; reported any noted abnormal effects to the physician/nurse practitioner as needed (PRN); provided a psychiatric consultation PRN; attempted non-pharmacological interventions prior to PRN use; completed an Abnormal Involuntary Movement Scale (AIMS) testing per policy; and referred to behavior grids as needed.

The POS dated 9/28/12 revealed orders for Zoloft (an antidepressant) 25 milligram (mg) by mouth (PO) once daily for psychosis; Depakote (an antiseizure/miscellaneous) 250 mg sprinkle capsules at bedtime and 125 mg capsule in the A.M. for psychosis; Haloperidol (an antipsychotic) 1 mg PO 3 times daily for agitation and 1 mg every (Q) 4 hours PRN for agitation; and Lorazepam (a benzodiazepine) 0.5 mg PO Q 4 hours PRN for anxiety.

Record review on 10/15/12 at approximately 2:00 P.M. revealed a lack of evidence of monitoring for the efficacy for Depakote Sprinkles, used for the diagnosis of psychosis, for the months of

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F 329	Continued From page 31 September and October 2012. Observation on 10/10/12 at 9:46 A.M. revealed the resident forcefully rocked her/himself back and forth while she/he sat in a Broda rocking chair with a lap tray, hitting the wall with the back of the Broda chair crying; and direct care staff U removed the lap tray and ambulated with the resident up/down the hallway with the use of a gait belt. Observation on 10/11/12 at 7:23 A.M. revealed the resident laid on a concave mattress and swung her/his legs over the left side of the bed while direct care staff V gathered her/his clothes; and direct care staff V replaced the resident legs back into bed. Staff interview on 10/11/12 at 3:27 P.M. with licensed nursing staff E stated staff used the behavioral monitoring forms for psychotropics, antidepressants, Depakote, and Haldol. Staff interview on 10/15/12 at 10:15 A.M. with licensed nursing staff F stated the resident received Zoloft for depression and crying; had episodes of yelling, kicking, hallucinations, and carried on a conversation with no one; staff monitored the behavioral medications on the behavior monitoring form; and nursing staff updated the behavioral monitoring forms with new orders. Staff interview on 10/15/12 at 2:32 P.M. with administrative nursing staff B stated staff initiated the behavioral monitoring forms with demonstrations of behaviors, if deemed necessary by the behavior meeting/team, social	F 329		

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F 329	Continued From page 32 services, and nursing; antidepressant, antianxiety, and staff monitored psychotropic medications on the behavioral monitoring form; staff monitored Depakote on the Medication Admission Record (MAR) as the side effects were listed on the MAR for each medication; if the side effects were present, nursing staff notified the physician. The policy and procedure dated 3/12 for Behavior Monitoring revealed any resident that received psychoactive medications would have a Behavior/Intervention Monthly Flow Record initiated which required documentation every shift. The facility failed to monitor for the efficacy of Depakote used for the diagnosis of psychosis for this resident.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. Based on observation, interview and record review, the facility failed to distribute and serve	F 371		

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F 371	Continued From page 33 food under sanitary conditions in the kitchen which served 51 of 53 residents. Findings included: - Observation in the kitchen food preparation area on 10/9/12 at 12:51 A.M. revealed dietary staff S had a hairnet on the back of his/her head, but the front of his/her hair was not covered. Observation further revealed dietary staff R had on a hairnet, but the back of his/her hair was not fully covered, and had a facial hair cover which did not cover all of his/her facial hair. Dietary supervisor Q and Registered Dietician U were also in the kitchen. During an interview on 10/9/12 at 1:00 P.M., dietary supervisor Q stated he/she checked that dietary staff had on hairnets, and stated staff S should have all of his/her hair covered in the hairnet, and staff R should have the hair in the back and the facial hair completely covered. Observation in the kitchen food preparation area on 10/9/12 at 4:51 P.M. revealed dietary staff T had a hairnet but the front on his/her hair was not fully covered with the hairnet. The facility provided the policy entitled Dress Code/Uniforms dated 3/12 which directed, "To prevent contamination of food or equipment, an apron and a hair restraint must be worn by both men and women. A hairnet must completely cover all hair including bangs and braids. A clean cap may be worn in place of a hairnet if hair is less than 2 inches long. No extended flap caps may be worn. Men with facial hair longer than 1/4 inch must wear a beard guard."	F 371		

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F 371	Continued From page 34 During an interview on 10/15/12 at 2:30 P.M., administrative staff A stated the Registered Dietician came in weekly and monitored the hairnets on the dietary staff. The facility failed to distribute and serve food under sanitary conditions in the kitchen which served 51 of 53 resident meals.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 16 residents. Based on observation, record review and interview, the pharmacy consultant DD identified the facility's failure to follow up on as needed pain medication for one resident (#2), failed to ensure the facility provided as needed medication as ordered for one resident (#2) and failed to provide adequate behavior monitoring for one resident (#8) of 3 residents sampled for unnecessary medications. Findings included:	F 428		

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- Resident #2's September 2012 Medication Administration Record (MAR) recorded the resident received as needed Lortab (narcotic pain medication) as ordered on 9-3-12 at 7:00 A.M.; 9-6-12 at 6:20 A.M. and 4:00 P.M.; 9-9-12 at 4:30 P.M.; 9-18-12 at 3:45 P.M. and 9-19-12 at 2:30 P.M. staff documented only once on the back of the MAR that the resident received the Lortab and the effectiveness. The facility failed to document the reason for the medication administration, location of pain and follow-up effectiveness in a timely manner after administration on 4 of the 6 times the resident received Lortab in the month of September 2012.

The care plan dated 10-2-12 directed staff to assess the resident for pain and medicate as ordered by the physician.

The Weekly Nursing Progress Note dated 10-8-12 recorded the resident with pain less than daily and had as needed Lortab.

Nurse's notes dated 9-28-12 (no time recorded) documented the resident's blood pressure at 6:30 P.M. was 230/77. Staff received a new order to administer Clonidine (blood pressure medication) 0.1 milligrams when the resident's systolic blood pressure was greater than 180 as needed three times a day.

The October 2012 Medication Administration Record (MAR) recorded blood pressures as follows:
10-4-12 182/94
10-5-12 192/87
10-6-12 184/70

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F 428	Continued From page 36 10-8-12 184/80 10-9-12 182/84 The MAR lacked evidence the resident received Clonidine as ordered on these dates. On 10-9-12 at 4:39 P.M., observation revealed the resident sat in his/her wheelchair in his/her room. On 10-11-12 at 12:55 P.M., licensed nursing staff C acknowledged staff should have administered the current order of as needed Clonidine 5 times this month and the staff did not administer this medication. During an interview on 10-15-12 at 3:01 P.M., administrative nursing staff B acknowledged the resident had 5 missed doses of Clonidine and started the incident report with 3 staff. Administrative nursing staff B stated staff called the physician and received an order to discontinue the Clonidine. Administrative nursing staff B stated the management team checked the MARs every day or every other day for accuracy and completeness. The Consultation Report for October 1, 2012 thru October 10, 2012 recorded 2 recommendations, but not regarding as needed medication follow up and not regarding the Clonidine. Observation on 10-9-12 at 4:39 P.M. revealed the resident in his/her wheelchair in his/her room. During an interview on 10-15-12 at 2:44 P.M., administrative nursing staff B stated as needed	F 428		

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medications should be followed up on within the hour and staff should document on the pain flow sheet.

During interview on 10-15-12 at 2:45 P.M., consultant staff W stated the follow up on pain medications should be on the pain flow record.

During interview on 10-15-12 at 3:01 P.M., consultant staff W acknowledged that the Lortab in September was not always followed up on.

Attempts to reach the pharmacist on 10-16-12 for interview via telephone and fax were unsuccessful.

The facility-provided policy entitled Pain Assessment dated 3/12 recorded a pain flow record would be maintained with the resident's Medication Administration Record. This was to be completed when the resident identified they had pain. Staff should record the date and time, site/location, intensity, precipitating/aggravating, interventions-medication/non-medication, intensity of pain after intervention, side effects and initials.

Pharmacy consultant DD failed to identify the lack of monitoring for the effectiveness of as needed pain medications, and the facility's failure to administer as needed blood pressure medication as ordered for this resident.

- The Physician's Order Sheet (POS) dated 9/28/12 for resident #8 revealed diagnoses of senile dementia (difficulty with memory), Alzheimer's disease (difficulty with memory),

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F 428	Continued From page 38 psychosis (an abnormal condition of the mind), and anxiety disorder (a pattern of constant worry). The Quarterly Minimum Data Set (MDS) dated 8/29/12 revealed the resident had long/short term memory problems; had severely impaired cognitive skills for daily decision making; had physical behavioral symptoms directed toward others with behaviors that occurred 1 to(-) 3 days; rejected care which occurred 1-3 days; required extensive assist with two plus (2+) persons assisting with bed mobility, transfers, walk in room/corridor, locomotion on the unit, dressing, eating, toileting, and personal hygiene; total dependence of 2+ persons assisting with bathing; and received antipsychotic medications. The care plan dated 9/12/12 for at risk for adverse side effects for antipsychotics and antidepressants revealed nursing staff administered medications as ordered; monitor for signs and symptoms of adverse effects of antidepressant medications; monitored for adverse effects of psychotropic medication; monitored for signs and symptoms of adverse effects of antianxiety medications; reported any noted abnormal effects to the physician/nurse practitioner as needed (PRN); provided a psychiatric consultation PRN; attempted non-pharmacological interventions prior to PRN use; completed an Abnormal Involuntary Movement Scale (AIMS) testing per policy; and referred to behavior grids as needed. The POS dated 9/28/12 revealed orders for Zoloft (an antidepressant) 25 milligram (mg) by mouth (PO) once daily for psychosis; Depakote (an antiseizure/miscellaneous) 250 mg sprinkle	F 428		

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capsules at bedtime and 125 mg capsule in the A.M. for psychosis; Haloperidol (an antipsychotic) 1 mg PO 3 times daily for agitation and 1 mg every (Q) 4 hours PRN for agitation; and Lorazepam (a benzodiazepine) 0.5 mg PO Q 4 hours PRN for anxiety.

Record review on 10/15/12 at approximately 2:00 P.M. revealed a lack of evidence of monitoring for the efficacy for Depakote Sprinkles, used for the diagnosis of psychosis, for the months of September and October 2012.

The Medication Regimen Review dated 8/13/12, 9/2/12, and 10/9/12 revealed no new irregularities.

Observation on 10/10/12 at 9:46 A.M. revealed the resident forcefully rocked her/himself back and forth while she/he sat in a Broda rocking chair with a lap tray, hitting the wall with the back of the Broda chair crying; and direct care staff U removed the lap tray and ambulated with the resident up/down the hallway with the use of a gait belt.

Observation on 10/11/12 at 7:23 A.M. revealed the resident laid on a concave mattress and swung her/his legs over the left side of the bed while direct care staff V gathered her/his clothes; and direct care staff V replaced the resident legs back into bed.

Interview on 10/9/12 at 4:40 P.M. with pharmacy consultant Y stated resident medications were reviewed monthly; reviewed antipsychotic/antidepressant medication for dose and to see if the dose could be decreased to

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maintain function without side effects; reviewed for appropriate need for the medication; and reviewed the behavior monitoring forms to ensure different classes of medications were not clumped onto one behavior form which "muddies the water".

Staff interview on 10/11/12 at 3:27 P.M. with licensed nursing staff E stated behavioral monitoring forms were used for psychotropics, antidepressants, Depakote, and Haldol.

Staff interview on 10/15/12 at 10:15 A.M. with licensed nursing staff F stated Zoloft was provided for depression and crying; the resident had episodes of yelling, kicking, hallucinations, and carried on a conversation with no one; the behavioral medications were monitored on the behavior monitoring form; and nursing staff updated the behavioral monitoring forms with new orders.

Staff interview on 10/15/12 at 2:32 P.M. with administrative nursing staff B stated the behavioral monitoring forms were initiated with demonstrations of behaviors, if deemed necessary by the behavior meeting/team, social services, and nursing; antidepressant, antianxiety, and psychotropic medications were monitored on the behavioral monitoring form; Depakote was monitored on the Medication Admission Record (MAR) as the side effects were listed on the MAR for each medication; if the side effects were present, nursing staff notified the physician.

The policy and procedure dated 3/12 for Behavior Monitoring revealed any resident that received

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F 428	Continued From page 41 psychoactive medications would have a Behavior/Intervention Monthly Flow Record initiated which required documentation every shift. The pharmacy consultant failed to recognize that the facility failed to monitor for the efficacy of Depakote used for the diagnosis of psychosis for this resident.	F 428		